No. 80-802

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In the Supreme Court of the United States

October Term, 1980

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER,
Petitioner,

vs.

BLUE CROSS OF KANSAS CITY AND
BLUE CROSS ASSOCIATION,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE
EIGHTH CIRCUIT

BRIEF OF RESPONDENT BLUE CROSS OF KANSAS CITY IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

The question presented is whether, under the unique facts of this case, the National Health Planning and Resources Development Act of 1974, considered in its entirety, expresses the intent of Congress that the antitrust laws should not apply to the conduct of private parties that decline to contract with a new hospital built without need approval in contravention of a Health Systems Plan developed under the Act, where that conduct is specifically authorized and encouraged by the Act and assists implementation of the Act.

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Respondent Blue Cross of Kansas City respectfully requests that this Court deny the Petition for Writ of Certiorari seeking review of the Eighth Circuit Court of Appeals' Opinion in this case. Blue Cross of Kansas City concurs in petitioner's statements under the headings *Opinions Below* and *Jurisdiction.*

STATUTORY PROVISIONS INVOLVED

The statutory provisions involved in this case include Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2 (Petition at 2), and the entire National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.*

STATEMENT OF THE CASE

Respondent Blue Cross of Kansas City adopts petitioner's factual statement, with the addition of the following material facts:

In 1973, Missouri entered into an Agreement pursuant to Section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1, which required, *inter alia,* that state approval be granted prior to commencement of new hospital construction. That Agreement was terminated on June 30, 1976, so that no agency was responsible under state law for limiting or controlling hospital expansion. (628 F.2d at 1053; App. A at 6a).

Mid-America Health Systems Agency (MAHSA) was designated by the Secretary of Health, Education and Welfare (HEW) in 1976 as the regional planning agency for the Kansas City metropolitan area under the National Health Planning and Resources Development Act of 1974 (the Health Planning Act). (628 F.2d at 1052-1053; App. A at 5a). MAHSA had as its responsibility "the provision of effective health planning for its health service area." 42 U.S.C. § 300l-2(b). The Act states that the local agency shall develop a Health Systems Plan (HSP) which shall be implemented "with the assistance of individuals and public and private entities." 42 U.S.C. § 300l-2. In developing its HSP, MAHSA determined that additional

hospital beds were not needed in the Kansas City metropolitan area, and announced that no approval would be granted for expansion, including new hospitals. (628 F.2d at 1054; App. A at 7a-8a).

In the absence of state legislation, Blue Cross of Kansas City determined that it would follow the directives of MAHSA as the regulatory agency charged with health services planning in the Kansas City area. (628 F.2d at 1053; App. A at 6a). Accordingly, on July 21, 1976, Blue Cross of Kansas City publicly announced:

> Since the State Planning Agency no longer exists, Blue Cross of Kansas City will look to the local Health Systems Agency for approval of such capital projects. That Health Systems Agency in the Kansas City metropolitan area is the Mid-America Health Systems Agency and in the balance of our operating area, Area II Health Systems Agency. *All projects not reviewed and approved by these Health Systems Agencies will not be reimbursible by Blue Cross of Kansas City.* 628 F.2d at 1053; App. A at 7a.

This policy remained in effect until 1979, when the State of Missouri reinstated its Agreement under Section 1122 of the Social Security Act, and additionally enacted Certificate of Need legislation pursuant to the Health Planning Act. (Appendix B to Respondent's Brief). Petitioner National Gerimedical Hospital applied for a Blue Cross participating hospital contract in 1977, although it had not sought or obtained approval from MAHSA prior to beginning construction. (628 F.2d at 1052, 1054; App. A at 4a, 7a). Blue Cross of Kansas City, in compliance with its announced policy, did not offer a participating contract to petitioner because petitioner had not received MAHSA's approval. (628 F.2d at 1054; App. A at 7a).

In 1977, the year in which petitioner hospital began construction, Missouri was the only state in which health care providers were not required to obtain agency approval prior to undertaking new development. All other states and the District of Columbia required agency approval under either Section 1122 of the Social Security Act or the Health Planning Act, and such requirements have remained continuously in force. Missouri is the only state in which such a gap in state enforcement has occurred. A list of all states summarizing the status of Certificate of Need legislation and Section 1122 Agreements is contained in Appendix B to Respondent's Brief.

REASONS WHY THE WRIT SHOULD BE DENIED

I.

The Decision Below Does Not Raise the Question Presented in the Petition

Petitioner misstates the holding of the Eighth Circuit in its *Question Presented.* The question stated in the Petition is whether a selected portion of the National Health Planning and Resources Development Act of 1974 is "so inconsistent with the antitrust laws" as to create a "blanket exemption" from those laws for a concerted refusal to deal, where there was "no involvement by a state or federal agency," where there was "no state or federal mandate or supervision of the parties or conduct involved," and where the federal statute "did not expressly immunize the boycott." This question is not raised by the decision below.

In attempting to persuade this Court to grant certiorari in this case, petitioner has created an unfounded illusion that the decision below represents a sweeping,

industrywide "blanket exemption" from the antitrust laws under the Health Planning Act. But that is not what the Court of Appeals actually held at all.[1] The *holding* was that respondent is immune from antitrust liability for the specific conduct alleged by petitioner, under the particular facts of this case and applicable provisions of the Health Planning Act.[2]

This case involves only one part of the health services industry—the supply of hospital beds. The particular illegal conduct alleged is respondent's decision not to contract with a new hospital whose facility was constructed without either seeking or obtaining need approval, in direct contravention of a Health Systems Plan developed by the regional Health Systems Agency officially designated under the Health Planning Act. Further, these activities occurred during a brief interval of time prior to Missouri's enactment of legislation formally implementing the Health Planning Act in the state.[3] Finally, both the language and congressional history of the Health Planning Act demonstrate that the specific conduct involved here was expressly authorized and intended under

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1. The Petition conspicuously avoids reference to the "holding" of the court below. Instead, and in an obvious attempt to create an image that this case has far-reaching implications beyond its own facts, petitioner repeatedly refers merely to "the decision below." Petitioner's failure to recognize the very limited scope of the Court of Appeals' actual holding in this case demonstrates the fundamental error in its entire argument.

2. 628 F.2d at 1057; App. A at 16a. There is language in the *District Court's* opinion which arguably could extend beyond the facts presented. 479 F. Supp. at 1021. But the *Court of Appeals'* opinion contains no such language and in fact expressly holds to the contrary.

3. Missouri later enacted such legislation, thus rendering impossible a recurrence of the circumstances in this lawsuit. See Part II of Respondent's Brief, *infra*.

the Act.[4] These circumstances render the holding of the court below an extremely narrow one.

The Court of Appeals' opinion makes clear that its decision must be limited to the specific circumstances presented. The Court began its analysis of the implied repeal issue by stating:

> While the doctrine of implied immunity is to be used sparingly and only when necessary . . . these provisions [of the Act] make *the instant situation* one well-suited for its use.
>
> The necessity of application of the doctrine of implied immunity arises if there is (1) a clear repugnancy between the antitrust laws *and the specific conduct at issue* and (2) if the intent of Congress is that implied repeal of the antitrust laws was intended. (Emphasis added). 628 F.2d at 1054; App. A at 8a.

The Court of Appeals later emphasized that the decision applies only to its specific facts by stating its holding in these terms:

> We affirm the district court's holding; the doctrine of implied immunity applies *to Blue Cross' voluntary cooperation* with the Congressionally designated HSA *in requiring National to obtain need approval from MAHSA prior to applying for a Blue Cross member-*

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4. Congress specifically found that competition does not work in this particular part of the health services industry. Based on that finding (and others), the Act establishes a regional Health Systems Agency (HSA) whose purposes include "restraining increases in the cost of providing . . . health services," and "preventing unnecessary duplication of health resources." 42 U.S.C. § 3001-2(a). Under the Act the functions of the HSA include development of a Health Systems Plan for its appropriate region, and implementation of that plan with the assistance of individuals and public and private entities. 42 U.S.C. § 3001-2(b).

ship contract. (Emphasis added). 628 F.2d at 1057; App. A at 15a.

On other occasions throughout the opinion the Court below was careful to reiterate the limited scope of its holding.[5]

In addition to the fact that the Court of Appeals did not hold there was a "blanket exemption" from the antitrust laws, the Court specifically referred to involvement by a federally-designated agency, MAHSA. (628 F.2d at 1055; App. A at 10a). It is clear that the Eighth Circuit's holding is predicated at least in part upon the existence of a federal regulatory scheme mandating the cooperation of private parties. (628 F.2d at 1054; App. A at 8a). Thus, the question which petition attempts to present simply does not exist on the record in this case.

II.

The Decision Below Is of Limited Precedential Value Because It Was Based Upon the Unique Factual Circumstances of This Case

This case presents factual circumstances which are extremely unlikely to recur. The facts of this case arose because of a gap in state enforcement legislation in Missouri which no longer exists and which did not occur in any other jurisdiction in the country. Since at least 1977 every state other than Missouri has had continuously in force a program requiring that hospitals obtain state or

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5. For example, the Court, following settled principle, quoted from *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. 694 (1975), that "implied immunity can be found in *'particular and discrete instances'* . . ." (Emphasis added). (628 F.2d at 1055; App. A at 11a). The Court later went on to note its agreement with the district court's finding of a clear repugnancy between the Act and antitrust laws because "the Act and regulatory scheme clearly call for *the action which has now become the basis of an antitrust claim.*" (Emphasis added). (628 F.2d at 1055-1056; App. A at 12a).

local certification prior to expanding facilities, either under Section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1, or under the Health Planning Act.[6] Missouri had terminated its certification program under Section 1122 of the Social Security Act in 1976, and did not enact new legislation under the Health Planning Act until 1979. For a three-year period no Missouri state law required that approval be granted before new hospital facilities were built. National Gerimedical Hospital was built during this gap in state enforcement legislation. *Only* in Missouri was there a hiatus in state enforcement,[7] and *only* in Missouri could a hospital have been built without obtaining prior certification from a state or local planning agency.

Regional health planning under the Health Planning Act has been in effect in Kansas City since 1975 when the Secretary of HEW designated Mid-America Health Systems Agency (MAHSA) as the Health Systems Agency (HSA) for the Kansas City metropolitan area. One of the major functions of the HSA under the Act is to conduct "need reviews" to determine whether new services or facilities planned by health care providers are needed in the regional planning areas. 42 U.S.C. § 3001-2 (f). If not needed, the HSA will not grant a certificate of need to enable the proposed development to proceed.

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6. The Health Planning Act was enacted in 1974. At that time, 47 states, including Missouri, had state approval requirements in effect. Texas and Vermont enacted legislation in 1975, followed by West Virginia and the District of Columbia in 1977. Missouri terminated its Section 1122 Agreement in 1976, so that when petitioner hospital began construction in 1977, Missouri was the *only* state in the Union that did not require prior agency approval before beginning hospital construction. A complete listing of all state programs and their date of enactment is provided in Appendix B to Respondent's Brief.

7. MEDICINE IN THE PUBLIC INTEREST, INC., CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT 3 (1978).

State legislation, however, is necessary in order to *require* health care providers to first obtain a certificate of need from an HSA before undertaking expansion. In Missouri, although MAHSA had a need review program in operation from 1976 onward, the lack of state enabling legislation between 1976 and 1979 meant that health care providers, including hospitals, were not required to seek MAHSA's approval prior to beginning new development. Petitioner took advantage of this gap in state legislation in order to construct National Gerimedical Hospital without first seeking a certificate of need from MAHSA.

Petitioner overstates its case in arguing that the decision of the Court of Appeals, based upon implied repeal of the antitrust laws, has far-reaching implications for the health care industry. Implied repeal was the sole issue here because of the unique circumstances in which this case arose. By virtue of state legislation currently existing in Missouri and elsewhere, other cases arising under the Act will not be decided on this basis. Instead, the recurring issue will be whether private conduct mandated by state legislation under the Act should be exempt from antitrust laws under the *Parker v. Brown*[8] or the *Noerr-Pennington*[9] doctrine.

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8. 317 U.S. 341 (1943). Legislation enacted by the states which may have an adverse effect on competition is not prohibited by the antitrust laws, nor is the action of private parties in compliance with state legislation. *Exxon Corp. v. Governor of Maryland*, 437 U.S. 117, 133 (1978), *rehearing denied*, 439 U.S. 884 (1978); *Lafayette v. Louisiana Power & Light Company*, 435 U.S. 389 (1978).

9. *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961), *rehearing denied*, 365 U.S. 875 (1961) and *United Mine Workers v. Pennington*, 381 U.S. 657 (1965). This doctrine "protects attempts to influence governmental units and instrumentalities in order to obtain legislation, redress, or action favorable to particular interests." *Huron Valley Hospital, Inc. v. City of Pontiac*, 466 F. Supp. 1301, 1312 (E.D. Mich. 1979). *See also Lamb Enterprises, Inc. v. Toledo Blade Company*, 461 F.2d 506 (6th Cir.), *cert. denied*, 409 U.S. 1001 (1972).

The decision below was predicated on implied repeal because of a quirk in Missouri state enforcement, which did not exist in other states and which no longer exists in Missouri. The unique facts of this case simply do not rise to a level of national importance, nor do the arguments made in Parts IA, IB and IC of the Petition enable petitioner to create a federal question of national importance.

A. The Decision Below Does Not Displace Competition in the Health Care Industry With Unsupervised Private Action

Petitioner's argument in Part IA of the Petition that the Eighth Circuit decision has displaced competition in the health care sector with unsupervised private action, creating an issue of national importance, contains two fallacies. First, petitioner characterizes the appellate decision as creating a "blanket exemption" to the antitrust laws, a position far removed from the actual holding of the Eighth Circuit.[10] Second, petitioner argues that competition is a basic premise underlying the Health Planning Act, and that the Eighth Circuit decision conflicts with this "premise." This is *not* the case. The urgent need for the Health Planning Act was based in large part upon the *failure* of competition to control skyrocketing health care costs and to efficiently allocate resources. As recognized in the Congressional Committee Report on the 1974 Act:

> The need for strengthened and coordinated planning for personal health services is growing more apparent each day. In the view of the Committee *the health care industry does not respond to classic marketplace*

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10. See Part I of Respondent's Brief, *supra*.

forces. The highly technical nature of medical service together with the growth of third party reimbursement mechanisms act to attenuate the usual forces influencing the behavior of consumers with respect to personal health services. (Emphasis added). S. Rep. No. 93-1285, 93d Cong., 2d Sess., 1974 U.S. Code Cong. & Ad. News 7842, at 7878.

The 1979 amendments to the Health Planning Act, rather than indicating Congress' intent to enhance competition in all areas of health care service, actually demonstrate Congress' increased recognition that competition is ineffective in many areas, notably with respect to inpatient health services, such as those involved in this case. Section 1502(b) of the Health Planning Act now states:

> (1) *The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished.* The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, particularly for inpatient health services and other institutional health services. As a result, there is duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services.
>
> (2) *For health services, such as inpatient health services and other institutional health services, for which competition does not or will not appropriately allocate supply* consistent with health systems agencies and State health plans, health systems agencies and State health planning and development *agencies should* in the exercise of their functions under this title *take actions* (where appropriate to advance the purposes of quality assur-

> ance, cost effectiveness, and access and the other purposes of this title) *to allocate the supply of such services.* (Emphasis added).

If competition has been "displaced" in the health care sector, it is Congress who has done so and not the Eighth Circuit.

Petitioner further mischaracterizes the holding of the Court of Appeals. The decision below does not substitute "unsupervised private action" for competition. The Court merely recognizes that conduct of private parties in compliance with federal legislation does not violate the antitrust laws. The key to the Eighth Circuit's reasoning is not "private action," but rather the intent of Congress. The Court properly concluded that Congress intended voluntary compliance by private parties in order to implement the Health Planning Act. (628 F.2d at 1056-1057; App. A at 12a-16a). That such compliance could violate the antitrust laws would yield a patently absurd result, so the Court of Appeals held that repeal of the antitrust laws for specific conduct in compliance with the Act must be implied. Petitioner's quantum leap in arguing that this decision eliminates competition in the health care industry is unjustified.

The decision below neither displaces competition in the health care industry nor substitutes private action for competition. This case does not present an issue of national importance warranting review by this Court.

B. Review of the Decision Below Will Not Clarify the General Ground Rules Governing Antitrust Liability in the Health Care Industry

The contention of petitioner in Part IB of the Petition that review of the decision below is required to clarify the scope of antitrust liability in the health care industry

is unsupported and incorrect. The facts of this case, which necessitated that the Eighth Circuit decision be based only on implied repeal, are unique. A decision by this Court on implied repeal, the sole legal question here presented, will provide no guidance to lower courts on the principal theory of other cases which may arise under the Act—the "state action" exemption to the antitrust laws.

The cases cited by petitioner illustrate this. *Huron Valley Hospital, Inc. v. City of Pontiac,* 466 F. Supp. 1301 (E.D. Mich. 1979), was decided specifically on "state action" grounds. Implied repeal of the antitrust laws was mentioned as an argument raised by defendant, but was *not* the basis for the district court's decision. Furthermore, in the absence of a ruling by the Sixth Circuit, it is mere conjecture by petitioner to suppose that implied repeal will be the basis of the appellate opinion in that case.

No opinion has even been announced in *North Carolina v. P.I.A. Asheville, Inc.* (Civ. No. A-C-80-29), where the district court has stayed all proceedings pending state agency determination. The legal theories that will eventually be adopted by the district court are a matter of speculation, but in light of the district court's deference to the state agency, it is likely that a decision in defendant's favor would be based upon a "state action" exemption.

This is simply not an appropriate case in which to define the scope of antitrust liability under the Health Planning Act. This case presents only the issue of implied repeal. That issue existed solely because of the gap in Missouri enforcement legislation, which has since been eliminated. Implied repeal alone is unlikely to be the basis for future decisions. The relationship of the "state action" exemption to the Health Planning Act may be

an issue to be resolved under the Act, but it is not presented by this case. A review of the present case necessarily would be limited in its scope and usefulness to the unique facts of this case, and would not provide guidance to lower courts on the very different antitrust issues confronting them under the Health Planning Act.

Petitioner attempts to create an additional problem by stating that the Department of Justice has adopted a position different from the decision below. This is untrue. The Eighth Circuit decision did not grant a "blanket exemption" for the health care industry, and the decision below is not inconsistent with the Department of Justice statement. Petitioner's effort to put the Eighth Circuit's comprehensive opinion on the same footing with a Department of Justice Business Review Clearance is clearly unwarranted. The same record has not been developed in the Justice Department determinations. The same principles are not involved. The factual situations are different and different standards apply. The two cannot be validly compared.

Similarly, petitioner's effort to raise additional questions by claiming that "appropriateness review" and Professional Standards Review Organization legislation are threatened by the Court of Appeals' decision are without basis and constitute an attempt to create antitrust problems where none currently exist. This case presents a narrow set of facts and a correspondingly narrow decision. Broad questions of antitrust liability are not involved here and cannot be created by petitioner so as to justify this Court's review.

C. The Decision Below Does Not Impair Other Decisions of This Court With Respect to the Health Care Industry

To argue, as petitioner does in Part IC of the Petition, that this decision will impair other decisions of this Court based on different facts and law is to seriously overstate the scope and effect of the Eighth Circuit's holding. Even a cursory reading of that opinion suffices to demonstrate that no questions involving "learned professions," the "state action" exemption, or interstate commerce were presented to or decided by the Eighth Circuit. Nothing in the Eighth Circuit opinion affects in any way those issues.

Petitioner states that "[t]he decision below would effectively undo this Court's decision in [*Hospital Building Company v. Trustees of*] *Rex Hospital,* [425 U.S. 738 (1976)]." (Petition at 14). *Rex Hospital* dealt solely with the scope of interstate commerce. The Court recognized, in its limited holding that the complaint should not have been dismissed for failure to state a claim:

> It may, of course, be that even though petitioner's complaint adequately alleges an effect on interstate commerce, further proceedings in this case will demonstrate that respondents' conduct in fact involves no violation of law, or indeed no substantial effect on interstate commerce. 425 U.S. at 747 n.5

The *Rex Hospital* opinion is in no way a decision on the merits. The Court anticipated that other issues might arise which would bar recovery by plaintiffs. The Eighth Circuit decision in the present case clearly does not conflict with this Court's decision in *Rex Hospital.*

Even more clearly, nothing in the decision below limits this Court's holding in *Group Life & Health Insurance Company v. Royal Drug Company,* 440 U.S. 205 (1979),

rehearing denied, 441 U.S. 917 (1979). Both the appellate and trial courts concluded that the *Royal Drug* opinion definitively controlled this case, and held that respondents were not entitled to an exemption under the McCarran-Ferguson Act. (628 F.2d at 1057; App. A at 15a; 479 F. Supp. at 1019). Petitioner's contention to the contrary is completely unfounded.

In summary, the decision below does not impinge upon or limit this Court's prior rulings. Other cases were decided upon dissimilar facts, dissimilar statutes and dissimilar legal theories. The unique facts of this case and the narrow ruling by the Eighth Circuit do not affect other decisions by this or any other court with respect to the health care industry.

III.

The Decision Below Properly Applies Settled Principles of Implied Repeal in a Narrow Factual Context and Is Fully Consistent With Prior Decisions of This Court

Petitioner presents specious reasoning to conclude that the decision below conflicts with applicable decisions of this Court. Petitioner first posits that the holding of the Eighth Circuit creates a "blanket exemption" from the antitrust laws under the Health Planning Act, and petitioner then explains reasons why creation of a "blanket exemption" conflicts with prior decisions of this Court. The obvious flaw in this argument is its erroneous premise. The decision below clearly does *not* hold that the Health Planning Act constitutes a "blanket exemption" from antitrust liability as petitioner suggests. Quite the contrary, the Court of Appeals' decision necessarily is strictly circumscribed by the narrow factual context presented, and its holding recognizes an implied repeal *only* with respect

to the *specific conduct* alleged under the *peculiar circumstances* in which it occurred.[11] Petitioner's theory that the opinion conflicts with prior decisions of this Court is totally without merit. Review by this Court on that ground is wholly unwarranted.

A. The Decision Below Does Not Conflict With Decisions of This Court by Extending the Doctrine of Implied Repeal to Statutes Involving No Federal Regulatory Scheme

Petitioner contends in Part IIA of the Petition that certiorari should be granted because the Court of Appeals' decision "extends the doctrine of implied repeal to statutes involving no federal regulatory scheme whatever." (Petition at 20). To the extent this contention is based on the unfounded presumption that the decision below creates a "blanket exemption" from antitrust liability, it is plainly without merit for the reasons previously stated. And to the extent petitioner also suggests that the decision below conflicts with applicable decisions of this Court by otherwise improperly extending the doctrine of implied repeal, that suggestion is equally without merit for at least two reasons.

First, the decision below is totally consistent with and follows prior decisions of this Court because the Court below expressly found that the Health Planning Act *does* enact a federal regulatory scheme. In the course of analyzing the implied repeal issue, the Court of Appeals stated:

> Missouri's lack of state participation did not affect the Act *which set up a regulatory scheme* which designated MAHSA as a regulatory need review agency. More specifically, it has no effect upon that portion

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11. See Part I of Respondent's Brief, *supra*.

> of the legislation *which calls for a regulatory system* which included the designated HSA implementing the HSP and the AIP with the assistance of individuals and public and private entities in its health service area. (Emphasis added). 628 F.2d at 1055; App. A at 10a.

The Court then proceeded to describe in detail "[t]he extent of this regulatory scheme" by referring to the findings of the District Court in that regard. (628 F.2d at 1055; App. A at 10a). The decision below clearly is not inconsistent with decisions of this Court applying the implied repeal doctrine in the context of a federal regulatory scheme.

Second, petitioner's suggestion that, under this Court's decisions, a "pervasive federal regulatory scheme" is an absolute condition precedent to finding a conflict with the antitrust laws justifying implied immunity, is incorrect. This Court has directly stated that a pervasive regulatory scheme is *not* an essential ingredient of the implied repeal doctrine in *Gordon v. New York Stock Exchange, Inc.*, 422 U.S. 659 (1975). In *Gordon*, this Court rejected precisely the argument petitioner makes here when the Court stated:

> The United States appears to suggest that only if there is a pervasive regulatory scheme, as in the public utility area, can it be concluded that the regulatory scheme ousts the antitrust laws. . . . It is true that in some prior cases we have been concerned with the question of the pervasiveness of the regulatory scheme as a factor in determining whether there is an implied repeal of the antitrust laws. . . . In the present case, however, respondents do not claim that repeal should be implied because of a pervasive regulatory scheme, but because of the specific provision of §19(b)(9) and

> the regulatory action thereunder. . . . Hence, whether the Exchange Act amounts to pervasive legislation ousting the antitrust acts is not a question before us. 422 U.S. at 688-689.

Under *Gordon,* petitioner's argument that the opinion below conflicts with decisions of this Court for lack of a required "pervasive federal regulatory scheme" necessarily fails.

Petitioner's imagined fear that absent review the decision below will breed uncertainty and confusion among lower courts regarding the scope of the implied immunity doctrine and the relationship of that doctrine to the "state action" exemption, is equally unfounded. To date three separate courts have examined the Health Planning Act and its legislative history, and each has concluded that Congress intended immunity from antitrust liability for actions taken pursuant to the Act.[12] This can hardly be described as uncertainty or confusion among the lower courts.

The only "uncertainty and confusion" pointed to by petitioner is a claimed conflict in the Eighth Circuit by virtue of the decision in *Sound, Inc. v. American Telephone & Telegraph Company,* No. 80-1047 (8th Cir., August 25, 1980). The *Sound, Inc.* decision further clarifies, rather than confuses, the scope of the implied immunity doc-

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12. In the first decision, the district court in the Eastern District of Michigan found that the legislative history of the Act demonstrated Congress' intent to partially repeal the antitrust laws. *Huron Valley Hospital, Inc. v. City of Pontiac,* 466 F. Supp. 1301, 1305 (E.D. Mich. 1979). In the second decision, the district court in the Western District of Missouri in this case discussed this issue at length and reached the same conclusion. 479 F. Supp. at 1019-1023. Finally, the panel of the Eighth Circuit in this case unanimously found likewise in the decision below. (628 F.2d 1054-1057; App. A at 8a-16a).

trine.[13] In any event, an intra-circuit conflict alone does not justify granting certiorari. *Davis v. United States*, 417 U.S. 333, 340 (1974).

With regard to the "state action" exemption, it is petitioner's argument here, not the decision below, which confuses this issue. The "state action" exemption from antitrust liability is not involved under the facts of this case, and the Court below expressly and accurately so ruled. (628 F.2d at 1054; App. A at 9a-10a). Therefore, this case is *not* an appropriate one in which to clarify the relation between these two doctrines,[14] and accordingly, certiorari is not proper to review that question in this case. *Kimbrough v. United States*, 364 U.S. 661 (1961) (writ of certiorari dismissed as improvidently granted where under the facts the question presented for review was "not presented with sufficient clarity in this case").

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13. In *Sound, Inc., supra*, the Eighth Circuit considered questions of antitrust liability in the context of the Communications Act of 1934. The Court treated separately and at great length both implied immunity and the state action exemption. The Court concluded that the conduct there at issue was not beyond reach of the antitrust laws under either theory.

14. During the relevant period in this case Missouri had no Certificate of Need legislation. Missouri later enacted such legislation, and currently virtually every other state in the Union has done so as well. Therefore, it is highly unlikely that the specific issue decided in this case—the question of implied immunity under the Health Planning Act wholly apart from any state action issue—will ever arise again. See Part II of Respondent's Brief, *supra*. In any event, there are cases pending in lower courts which present the implied immunity vis-a-vis state action exemption issue petitioner urges this Court to decide in this case. *See, e.g., Huron Valley Hospital, Inc. v. City of Pontiac*, 466 F. Supp. 1301 (E.D. Mich. 1979). This case should not be utilized to decide that issue, if further decision be needed.

B. The Decision Below Does Not Conflict With Decisions of This Court by Extending the Doctrine of Implied Repeal to Private Voluntary Conduct Subject to No Governmental Oversight

Petitioner's "governmental oversight" argument in Part IIB of the Petition reflects a fundamental misconception of the true basis for invoking the implied immunity doctrine. The doctrine is *not* founded on the presence of "oversight" by a regulatory agency, as petitioner suggests. The true basis for the doctrine is the *intent of Congress* to exempt the conduct involved from the antitrust laws. Regulatory oversight is but one possible indication of such intent.[15] This Court's decisions make it quite clear that the single, most fundamental premise of the implied repeal doctrine is congressional intention to afford such immunity. *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. 694, 720-722, 726-727 (1975); *Gordon v. New York Stock Exchange, Inc.*, 422 U.S. 659, 663-667, 686, 690-691 (1975); *Federal Maritime Commission v. Seatrain Lines, Inc.*, 411 U.S. 726, 729, 736-743 (1973); *Ricci v. Chicago Mercantile Exchange*, 409 U.S. 289, 302-303 (1973); *United States v. Philadelphia National Bank*, 374 U.S. 321, 350-352 (1963); *Silver v. New York Stock Exchange*, 373 U.S. 341, 364 (1963), *rehearing denied*, 375 U.S. 870 (1963); *Pan American World Airways, Inc. v. United States*, 371 U.S. 296, 304-305, 311-312 (1963); *United States v. Borden Company*, 308 U.S. 188, 198-199, 204 (1939).

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15. *See, e.g., MCI Communications Corporation v. American Telephone & Telegraph Company*, 462 F. Supp. 1072, 1083 (N.D. Ill. 1978), *aff'd*, 594 F.2d 594 (7th Cir. 1978), *cert. denied*, 440 U.S. 971 (1979); *Oahu Gas Service, Inc. v. Pacific Resources, Inc.*, 460 F. Supp. 1359, 1372 (D. Hawaii 1978).

In finding an implied repeal in this case, the Eighth Circuit focused on congressional intent by examining both the language of the Health Planning Act itself and its legislative history. Based on that analysis the Court below found that it was indeed the intent of Congress to afford an exemption from antitrust liability for the particular conduct in question. (628 F.2d at 1054-1057; App. A at 8a-16a). The decision below is in direct accord with the decisions of this Court in applying the doctrine of implied repeal.

It is difficult to meaningfully distinguish between petitioner's arguments based on "no governmental oversight" and "no federal regulatory scheme." As already discussed, the Court below specifically found that the Health Planning Act does in fact create a federal regulatory scheme governing the conduct involved in this case, and that would also appear to dispel petitioner's imagined conclusion that this case involves "no governmental oversight whatever."[16]

C. The Decision Below Properly Follows and Applies the Principles Governing Implied Repeal Established by This Court

Petitioner argues, in Part IIC of the Petition, that the decision below conflicts with principles governing implied repeal established by this Court because "blanket

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16. Petitioner greatly exaggerates the circumstances in this case by describing respondent's actions as "private voluntary conduct subject to no governmental oversight whatever." This misstates the facts. Respondent's conduct cannot fairly be characterized as purely voluntary, as it was found to be expressly authorized and intended under directives of the Health Planning Act—the action was taken pursuant to a Health Systems Plan developed by MAHSA as required under the Act and the action was deemed necessary by MAHSA to assist in implementation of the Plan, all as directed and contemplated under the Act. Furthermore, the combination or conspiracy alleged by petitioner presumably included as a participant MAHSA, which was a quasi-public agency during the relevant period and is a fully state-sanctioned public agency now.

exemptions have been uniformly disapproved by this Court." (Petition at 24). Again, this argument disregards the narrow factual context involved in this case and the limited scope of the actual holding of the Eighth Circuit.

The Court of Appeals fully recognized and followed the principle that implied immunity from antitrust liability should be narrowly limited to that required to make the regulatory scheme work. The Court directly noted at the outset of its analysis that "the doctrine of implied immunity is to be used sparingly and only when necessary" (628 F.2d at 1054; App. A at 8a), and the Court later reiterated that "implied immunity can be found in 'particular and discrete instances' . . .", quoting from *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. 694, 734 (1975). (628 F.2d at 1055; App. A at 11a). The Court found a "clear repugnancy" between the Health Planning Act and the antitrust laws as regards the particular conduct at issue (628 F.2d at 1055-1056; App. A at 12a), and also found based on the legislative history of the Act that Congress intended such conduct to be exempt from antitrust liability (628 F.2d at 1056-1057; App. A. at 12a-16a), all as required under this Court's applicable decisions. *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. 694, 721-722 (1975); *Gordon v. New York Stock Exchange, Inc.*, 422 U.S. 659, 682, 691 (1975); *Federal Maritime Commission v. Seatrain Lines, Inc.*, 411 U.S. 726, 729, 733 (1973); *United States v. Philadelphia National Bank*, 374 U.S. 321, 350-352 (1963); *Pan American World Airways, Inc. v. United States*, 371 U.S. 296, 304-305, 311-312 (1963); *United States v. Borden Company*, 308 U.S. 188, 198-199 (1939).

Thus, petitioner's characterization that the Court below "went out of its way to find a conflict in direct contravention of the precedents of this Court," (Petition at 24), inaccurately and unfairly describes the analysis by the Court below. In reality, the Court of Appeals

followed and properly applied the settled principles of implied repeal within the unique factual context presented. Where, as here, any asserted conflict in decisions only arises from differences in the facts, and not in application of principles of law, review by certiorari is not warranted. *Sanchez v. Borras,* 283 U.S. 798, 798-799 (1931); *Wisconsin Electric Company v. Dumore Company,* 282 U.S. 813 (1930).

Petitioner's final argument is that the decision below does not follow the rule of statutory interpretation that the specific statement of an exemption is the exclusion of any others, and thereby conflicts with decisions of this Court ruling that antitrust immunity should not be implied beyond any express statutory exemption. This argument fails because it overlooks the reason for the rule, which is to determine the *intent of Congress* in enacting the statute in question. The rule has no application where the intent of Congress is otherwise evident. Indeed, in the very case cited by petitioner to invoke that "basic rule of statutory interpretation," *National Railroad Passenger Corporation v. National Association of Railroad Passengers,* 414 U.S. 453 (1974), *rehearing denied,* 415 U.S. 952 (1974), this Court after noting the "rule" went on to state:

> But even the most basic general principles of statutory construction must yield to clear contrary evidence of legislative intent. 414 U.S. at 458.

In this case, contrary to the four cases referred to in the Petition,[17] the legislative history of the Health Plan-

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17. *Federal Maritime Commission v. Seatrain Lines, Inc.,* 421 U.S. at 733; *California v. Federal Power Commission,* 369 U.S. at 483; *Carnation Company v. Pacific Westbound Conference,* 383 U.S. at 216-217; *United States v. Borden Company,* 308 U.S. at 201. (Petition at 25). In none of those cases was there any finding, as there is in this case, that the legislative histories of the statutes involved clearly demonstrated congressional intention to immunize the conduct involved from antitrust liability.

ning Act, considered together with the specific provisions of the Act itself, clearly reflect Congress' intent to exempt from the antitrust laws the particular conduct involved here. The Court below found an implied repeal only after examining the legislative history of the Act "in order to determine the congressional intent in regard to immunity." (628 F.2d at 1056; App. A at 12a). Therefore, the decision below does not conflict with prior decisions of this Court applying the rule of statutory construction relied on by petitioner. In fact, this Court has recognized that antitrust immunity *can* be implied *despite* a grant of express immunity which does not cover the conduct charged. *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. 694, 720 (1975) (antitrust immunity implied under § 22(f) of the Investment Company Act of 1940 despite the inapplicability of the express immunity granted under § 22(d) of the Act); *Pan American World Airways, Inc. v. United States*, 371 U.S. 296, 304-310 (1963) (implied antitrust immunity held applicable to actions which were beyond the express immunity provision of § 414 of the Federal Aviation Act). *See also Hughes Tool Company v. Trans World Airlines, Inc.*, 409 U.S. 363, 385-386 (1973), *rehearing denied*, 410 U.S. 975 (1973).

The decision below does not conflict with any of the principles governing implied repeal established by applicable decisions of this Court and, accordingly, the instant petition should be denied on that ground.

CONCLUSION

For the above reasons, Respondent Blue Cross of Kansas City respectfully requests that the Petition for Writ of Certiorari be denied.

Respectfully submitted,

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APPENDIX

APPENDIX A

Opinion of the Eighth Circuit Court of Appeals

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,
Appellant,

v.

BLUE CROSS OF KANSAS CITY, BLUE CROSS ASSOCIATION,
Appellees.

(Filed July 22, 1980)

Before STEPHENSON and MCMILLIAN, Circuit Judges, and SACHS, *District Judge.

STEPHENSON, Circuit Judge

The National Gerimedical Hospital, plaintiff-appellant, appeals from a summary judgment granted to defendant-appellee Blue Cross of Kansas City. National had charged Blue Cross and others[1] with violations of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. The trial court[2] found Blue Cross' activities to be taken pursuant

*The Honorable Howard F. Sachs, United States District Judge for the Western District of Missouri, sitting by designation.

1. Blue Cross of Kansas City and Blue Cross Association were named defendant coconspirators. There were several non-defendant coconspirators listed in the plaintiff's complaint, including Mid-America Health Systems Agency, Inc. (MAHSA).

2. The Honorable Russell G. Clark, United States District Judge for the Western District of Missouri.

to Public Law 93-641, the National Health Care Planning and Resources Development Act of 1974, 42 U.S.C. § 300k, *et seq.*; that there was a repugnancy between the Act and the antitrust laws; and that consequently, under the doctrine of implied immunity, Blue Cross' activities were immune from the antitrust laws. *National Gerimedical Hospital & Gerontology Center v. Blue Cross,* 479 F. Supp. 1012 (W.D. Mo. 1979). We affirm the district court.

I. Statutory Background

The related health care statutes, as they existed during the relevant time period, are as follows.

Prior to the National Health Care Planning and Resources Development Act of 1974, the Public Health Service Act, 42 U.S.C. § 291, *et seq.* (known as the Hill-Burton Act) was the primary legislation channeling federal funds to states in support of construction and modernization of health care facilities. The Hill-Burton Act provides, as does much federal legislation involving state cooperation, for voluntary participation by the states. The participating state submits a state plan to HEW, which designates a particular state agency to be in charge of administering the state program and determining, *inter alia,* the need for new or expanded health care facilities. While an applicant could build without approval by the state agency, such applicant would not be eligible for reimbursement by the federal government. *Lakeside Mercy Hospital, Inc. v. Indiana State Board of Health,* 421 F. Supp. 193, 196-97 (N.D. Ind. 1976).

Other prior legislation providing for channeling federal funds into health care programs includes the Public Health Service Act § 314, 42 U.S.C. § 246 (amended 1978 and 1979). Under this program, federal funds are channeled to participating states that submit, and have approved

by HEW, a Comprehensive Health Planning State Plan. This legislation provides for a state agency to be designated to screen health care applications in order to verify the need for new facilities and programs under the approved state plan, and also, in cooperation with the state agency, the Act provides for Area Comprehensive Health Planning Agencies. *Id.* at 197.

Section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1 (amended 1978 and 1979), enacted in 1972, provides for a participating state program for repayment provisions for Medicaid and Medicare, for which repayment prior to that time had not been dependent upon need approval by any of the various state health agencies (those designated by the state pursuant to compliance with federal requirements in order to be a participating state). Section 1122 of the Social Security Act authorizes HEW to enter into agreements with participating states whereby a state agency is designated as a health planning agency. This agency develops a state plan and makes recommendations as to the need of proposed expenditures for health care facilities, in conformity with regulations promulgated by HEW. Once final approval by HEW is received, the capital expenditure qualifies for purposes of reimbursement, via Medicaid and Medicare payments, the portion of fees allocable to return of depreciation, debt service and other capital related expenditures. *Id.*

The purpose of the National Health Care Planning and Resources Development Act of 1974, also providing for a participating state program, is "to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy." 42 U.S.C. § 300k(b).

Part B of the Act, 42 U.S.C. § 3001, provides for the establishment of health service areas and corresponding health systems agencies (HSAs). The purposes of the HSAs as stated in the Act include, *inter alia,* "preventing unnecessary duplication of health resources." 42 U.S.C. § 300*l*-2(a). In order to accomplish its purposes, the HSA is to establish a health systems plan (HSP) and an annual implementation plan (AIP) which will achieve the goals of the HSP. 42 U.S.C. § 300*l*-2(b)(2). The Act specifically provides that the HSA shall implement the HSP and AIP, and "*shall* seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entitites in its health service area." 42 U.S.C. § 300*l*-2(c)(1) (emphasis added). It is this section of the Act upon which the district court primarily rests its finding of antitrust immunity for the actions of Blue Cross.

II. Facts

Construction of the National Gerimedical Hospital began in August 1976 and was completed in September 1978. On October 4, 1977, Hospital submitted to Blue Cross a request for a member hospital contract. Pursuant to such contracts Blue Cross reimburses individual members the cost of all covered health services received at member hospitals. If health services are received by individual members at nonmember hospitals, Blue Cross individual members receive only up to eighty percent of the cost of the covered medical services. Also, for health services received at member hospitals, Blue Cross reimburses or pays the hospital for the services provided its individual members; with a nonmember hospital, the reimbursement is paid to the individual member, not to the hospital.

Blue Cross advised Hospital that Hospital must first secure need approval of Mid-America Health Services

Agency (MAHSA) in order to be eligible for favorable consideration by Blue Cross for a member hospital contract.

MAHSA, named as a non-defendant alleged coconspirator,[3] is a private not-for-profit Missouri corporation engaged in voluntary health planning. MAHSA was conditionally designated an HSA under the Act and was notified of its designation for the eight county bi-state region of the metropolitan Kansas City area by letter from HEW on April 7, 1976. *Mid-America Regional Council v. Mathews*, 416 F. Supp. 896, 899 (W.D. Mo. 1976). Thus during the relevant time period of this case, MAHSA enjoyed this status.

Prior to this time period, Missouri had participated in the Social Security Act § 1122 Capital Health Care Expenditures Program, which included a State Planning Agency that performed section 1122 program reviews, as discussed *infra*, 42 U.S.C. § 1320a-1 (amended 1978 and 1979). Blue Cross had required that large capital expenditures be approved by the local and regional planning arm of the section 1122 State Planning Agency before, *i.e.*, a hospital could be a member institute. This Capital Expenditure Program, as discussed *infra*, was designed to assure that federal funds appropriated for Medicaid and Medicare were not used to support unnecessary capital expenditures for health care facilities.

Area agencies established under 42 U.S.C. § 246 (amended 1978 and 1979), discussed *infra*, Area Comprehensive Health Planning Agencies (CHPs), were used in conjunction with the need approvals necessary under 42 U.S.C. § 1320a-1 (amended 1978 and 1979). The applicant for Medicaid and Medicare cost reimbursement had to seek a favorable recommendation from the CHP and

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3. *See* note 1 *supra*.

secure a favorable determination of need from the state planning agency, the Missouri State Health Planning and Development Agency. The CHP for Missouri was MAHSA. The National Health Planning and Resources Development Act of 1974 gives preference to § 246 area agencies, CHPs and existing regional planning areas. 42 U.S.C. § 300*l*-4(b)(4) and § 300*l*(a)4.

On June 30, 1976, Missouri, a participating state under 42 U.S.C. § 1320a-1 (amended 1978 and 1979) since 1973 refused to renew Missouri's contract with HEW and Missouri's Program for Capital Health Care Expenditures was terminated.

On July 21, 1976, as reflected by a "Special Newsletter" to Blue Cross member hospitals in Missouri, Blue Cross gave notice that all projects in the Kansas City metropolitan area not reviewed and approved by MAHSA would not be reimbursible by Blue Cross of Kansas City.

> Blue Cross of Kansas City has been observing with considerable interest the events regarding the State of Missouri's cancellation of the SSA-1122 Capital Expentiture Program. It appears at this time that the final position of the Department of Health, Education, and Welfare on this matter has not been clarified with respect to reimbursement sanctions.[4] It also appears that the State of Missouri has no intention of reinstating the State Comprehensive Health Planning Agency to perform the SSA-1122 program review.
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> In view of this action, the Provider Relations Committee of the Blue Cross Board of Trustees felt it necessary to advise all Missouri Member Hospitals

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4. Appellant advises us that no question has been raised concerning Hospital's entitlement to full Medicare reimbursement.

of our position on this matter. As you are aware, the Member Hospital Contract contains a provision that capital expenditures of over $350,000 or 5% of the hospital's operating expense in the most recent fiscal year, whichever is lesser, be approved by the local or regional planning agency. Since the State Planning Agency no longer exists, Blue Cross of Kansas City will look to the local Health Systems Agency for approval of such capital projects. That Health Systems Agency in the Kansas City metropolitan area is the Mid-America Health Systems Agency and in the balance of our operating area, Area II Health Systems Agency. *All projects not reviewed and approved by these Health Systems Agencies will not be reimbursible by Blue Cross of Kansas City.*

Therefore, we urge you to continue working with these agencies and Blue Cross of Kansas City in future planning needs for your hospital. Should you have any questions regarding our position on this matter, please do not hesitate to consult with us.

MAHSA was, of course, designated as the HSA under the Act. However, Missouri, during the relevant time period, had no law implementing the Act in Missouri nor designating any state agency thereunder in accordance with 42 U.S.C. § 300m.

MAHSA had publicly stated that it would disapprove and not consider favorably the addition of any acute care hospital beds; acute care hospital beds are the type Hospital provided; Hospital did not submit an application for need review to MAHSA; Hospital's application for a member contract with Blue Cross was denied in March 1978 by Blue Cross because Hospital had not received approval through the voluntary health planning process as required by the Special Newsletter. Hospital then filed this lawsuit.

III. Analysis

National argues that by requiring National to get need approval from MAHSA before it applies for a member hospital contract with Blue Cross, Blue Cross violates the antitrust laws. National contends that the requirement constitutes a contract, combination or conspiracy in restraint of trade, Sherman Act § 1, 15 U.S.C. § 1, and an abuse of Blue Cross' monopoly power in the private health care reimbursement plan market, Sherman Act § 2, 15 U.S.C. § 2.

What defeats National's otherwise appealing argument are the specific provisions of the National Health Planning and Resources Development Act for voluntary cooperation and assistance of private entities and persons in the community and health care market. While the doctrine of implied immunity is to be used sparingly and only when necessary, *Gordon v. New York Stock Exchange, Inc.*, 422 U.S. 659 (1975), these provisions make the instant situation one well-suited for its use.

The necessity of application of the doctrine of implied immunity arises if there is (1) a clear repugnancy between the antitrust laws and the specific conduct at issue and (2) if the intent of Congress is that implied repeal of the antitrust laws was intended. *Essential Communication Systems, Inc. v. AT&T*, 446 F. Supp. 1090, 1094-95 (D.N.J. 1978).

As to the first prerequisite, the district court herein stated its finding of repugnancy best when it stated:

> If the Court were to find that private business working in conjunction with the health systems agency established by the Act in their area to achieve the goals of the Act were liable or might be liable under

> the antitrust laws for their action, then * * * the accomplishment of the purpose of the goals of the Act would be effectively foreclosed.

National Gerimedical Hospital & Gerontology Center v. Blue Cross, supra, 479 F. Supp. 1012, 1021 (W.D. Mo. 1979).

National's emphasis upon the fact that Missouri was not a participating state—"at all times here pertinent, Missouri had no law implementing P.L. 93-641 in Missouri nor designating any state agency thereunder in accordance with 42 U.S.C. § 300m" (brief for appellant at 12-13)—misses the focus of the doctrine of implied immunity. The doctrine should not be confused with the state action exemption to the antitrust laws as articulated in *Parker v. Brown,* 317 U.S. 341 (1943). The doctrine of implied immunity, in fact,

> is actually a subspecie of implied statutory repeal. *See, Gordon v. N.Y. Stock Exchange,* 422 U.S. 659, 682, 95 S.Ct. 2598, 45 L.Ed.2d 463 (1975), and *U. S. v. Southern Motor Carriers Rate Conference,* 439 F. Supp. 29, 35 (N.D. Georgia, 1977). It is one of several distinct judicially created rules, which include "primary jurisdiction" and "exhaustion of administrative remedies", designed to resolve potential conflicts between two regimes with federal statutory authorization to regulate the conduct of business entities: federal administrative agencies and federal courts enforcing (among others) the antitrust laws.
>
> The antitrust laws posit that the public interest is best served when business enterprises are compelled to compete in markets free of anti-competitive restraints. In contrast, the basic premise of administrative regulation is that the freedom of business en-

> tities must be in some degree curtailed to maximize the general welfare. When the same conduct falls within the scope of both the antitrust laws and a regulatory scheme, potential conflicts of competency and policy are resolved under the doctrine of implied immunity.

Essential Communication Systems, Inc. v. AT&T, supra, 446 F. Supp. at 1094 (footnote omitted). Missouri's lack of state participation did not affect the Act which set up a regulatory scheme which designated MAHSA as a regulatory need review agency. More specifically, it has no effect upon that portion of the legislation which calls for a regulatory system which included the designated HSA implementing the HSP and AIP "with the assistance of individuals and public and private entities in its health service versa." 42 U.S.C. § 300*l*-2(c)(1).

The extent of this regulatory scheme is demonstrated by the district court's discussion.

> Mid-America Health Systems Agency was one of 205 regional health systems agencies established under the Act * * *. In November of 1977 Mid-America Health Systems established a health systems plan for 1978 through 1982 in this region. Increasing hospital costs and unnecessary duplication of facilities and equipment were considered two of the biggest problems in this region. The health systems plan adopted by Mid-America Health Systems recognized:
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> Problem—The acute inpatient care system does not function in a coordinated manner which is cost-effective in the delivery of acute care services at the most appropriate level consistent with quality standards. (Health Systems Plan at pp. 6-19.)

The goal in this area was recognized as:

> Goal: Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner. (Health Systems Plan at pp. 6-19.)

To implement this goal MAHSA established a number of objectives in this area and specified particular methods that could be utilized to achieve each objective. Objective No. 4 seeks to:

> Objective #4
>
> Maintain a rate of increase in total expenditures for hospital care services which does not exceed the rate of increase in the medical care services component of the Consumer Price Index. (Health Systems Plan at pp. 6-21.)

As one of the nine methods set forth to meet this goal, Mid-America Health System suggested:

> (6) Third party payors and the hospital community should work together to develop uniform reporting systems and procedures such that meaningful hospital-to-hospital and year-to-year hospital cost and service-by-service utilization comparisons can be made. (Health Systems Plan at pp. 6-22.)

National Gerimedical Hospital & Gerontology Center v. Blue Cross, supra, 479 F. Supp. at 1020-21. Implied immunity can be found in "particular and discrete instances to assure that the federal agency entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under

the antitrust laws." *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. 694, 734 (1975).

We agree with the district court's finding of clear repugnancy between the Act and the antitrust laws, as the Act and regulatory scheme clearly call for the action which has now become the basis of an antitrust claim.

We now examine the history of the Act in order to determine the congressional intent in regard to immunity. The district court concluded, after a thorough review of the legislative history, that it was the intent of Congress to immunize this type of voluntary action from the antitrust laws. We cannot improve on the district court's discussion:

> In essence the antitrust laws posit that the public interest will be served best when business enterprises are compelled to compete in markets free of anti-competitive restraints. * * * The concern of the Senate Committee that considered the health care legislation at issue here was the failure of the health care industry to "respond to classic marketplace forces." See Volume 4, U.S. Code Cong. & Admin. News at p. 7878, U.S. Code Cong. & Admin. News 1974, p. 7878. In the Committee's view:
>
> > The highly technical nature of medical services together with the growth of third party reimbursement mechanisms act to attenuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's immediate incentive to contain expenditures. Volume 4, U.S. Code Cong. & Admin. News at p. 7878.

The Committee expressed concern over increasing hospital costs and improper utilization of existing facilities. Volume 4, U.S. Code Cong. & Admin. News at pp. 7893-4. The Committee in fact stated:

> The recent rapid acceleration in the costs of personal health services, far outstripping the rate of inflation in other sectors of the economy, has caused the Committee great concern. Although recognizing the increase in costs experienced by health care providers attributable to general inflation, the Committee, wishes to express its concern with respect to the disproportionately high rate of increase in costs of health care services. Volume 4, U.S. Code Cong. & Admin. News at p. 7895.

The Committee attributed many of the cost and duplication problems in the health care industry to reimbursement programs like the ones these defendants sponsor. The legislative history indicates to this Court that any attempts by companies such as these defendants to reduce costs and duplication were to be welcomed and were considered essential to a successful program of cost reduction. In summarizing the Act, the Committee stressed:

> The long-range goal plan is expected to provide for the prevention of unnecessary duplication of resources and assure that quality health services will be available and accessible in a manner which assures continuity of care at reasonable costs for all residents of the area, and which is responsive to the needs and resources of the area. U.S. Code Cong. & Admin. News at p. 7887.

Further, the Committee indicated:

> A health planning agency is directed to seek to implement its long-range goal plan and short-term priorities plan with the assistance of individuals and public and private entities in its health area. In so doing, the agency is directed to provide technical assistance, to the extent practicable, to such entities in bringing about consistency with its health plan. Volume 4, U.S. Code Cong. & Admin. News at p. 7888.

This interpretation of the legislative history is further supported by Representative Paul Rogers in debates over subsequent amendments to this Act. Representative Rogers expressed concern over interpretations of the National Health Planning and Resource Development Act of 1974:

> Concern has been expressed that HSA's and health care providers who voluntarily carry out the mandates of the health planning laws (titles XV and XVI of the Public Health Service Act) may be in violation of the antitrust laws.
>
> The antitrust laws prohibit actions which have the effect of restraining trade or competition. We have found, however, that there is minimal price competition within some parts of the health sector and that often the only competition is around the provision of services. One undesirable result of service competition has been that hospitals and other health care providers have acquired duplicative and expensive equipment and facilities which have led to higher costs for the consumer. In enacting Public Law 93-641, which added titles XV and XVI to the Public Health Service Act, the Congress made a specific judgment that con-

trol of the development of health care facilities was needed even though price and service competition might be restrained, and created a health planning system that could promote the efficient use of health resources through the regulation of and voluntary action by providers.

Title XV requires HSA's to bring together both consumers and providers to plan for an efficient health care system that will meet the area's needs. The HSA governing body is to make decisions in its health systems plan and in appropriateness [sic] review recommendations that affect market allocation . . . . In doing so, the HSA may develop institution-specific recommendations; . . . or develop broader recommendations, such as, three cardiac catheterization laboratories in the area should be consolidated. In either case, it is congressional intent that providers and consumers work together in cooperation with the HSA to determine how best to carry out such recommendations. Without the voluntary cooperation of providers, the provision of title XV dealing with the development of a plan and the review of existing institutional health services could not be carried out.

. . . congressional intent was for the HSA, the congressional intent was for the HSA, the provider seeking the certificate of need and other providers which might seek to provide similar services to coordinate their activities to assure that new institutional health services are developed in accordance with the health systems plan for the area.

Although Public Law 93-641 contains no specific exemption from the antitrust laws, an analysis

> of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, Public Law 93-641 simply could not be implemented. Congressional Record House, No. 18 Part 1, p. H11962-H11963.

National Gerimedical Hospital & Gerontology Center v. Blue Cross, supra, 479 F. Supp. at 1021-23.

We adopt the district court's discussion, as set out above. We affirm the district court's holding; the doctrine of implied immunity applies to Blue Cross' voluntary cooperation with the congressionally designated HSA in requiring Hospital to obtain need approval from MAHSA prior to applying for a Blue Cross membership contract.

Appellee Blue Cross also argues that the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, exempts the challenged conduct from the federal antitrust laws. We agree, in all respects, with the district court's holding that *Group Life & Health Insurance Co. v. Royal Drug Co., Inc.*, 440 U.S. 205 (1979) (defining "the business of insurance" in connection with the McCarran-Ferguson Act) controls. *National Gerimedical Hospital & Gerontology Center v. Blue Cross, supra,* 479 F. Supp. at 1016-19. Thus, we hold that the McCarran-Ferguson Act insurance exemption is not applicable in this case.

The district court is affirmed.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS, EIGHTH CIRCUIT.

APPENDIX B

State Certificate of Need Legislation and Section 1122 Agreements

State	Certificate of Need Legislation	Effective (Termination) Date §1122 Agreement
ALABAMA	Ala. Code §§ 22-21-260 *et seq.* (1977)	9/18/73 (6/30/80)
ALASKA	Alaska Stat. §§ 18.07.011 *et seq.* (1977)	4/1/74
ARIZONA	Ariz. Rev. Stat. §§ 36-401 *et seq.* (1971)	
ARKANSAS	Ark. Stat. Ann. §§ 82-2301 *et seq.* (1975)	7/1/73
CALIFORNIA	Cal. Health & Safety Code §§ 437 *et seq.* (1969)	
COLORADO	Colo. Rev. Stat. §§ 25-3-501 et seq. (1973)	3/1/74 (6/30/79)
CONNECTICUT	Conn. Gen. Stat. §§ 19-73a *et seq.* (1969)	
DELAWARE	Equitable Health Planning and Review, Del. Code tit. 16, §§ 9301 *et seq.* (1978)	7/1/73
DISTRICT OF COLUMBIA	1978 D.C. Code Legis. & Admin. Serv. 2-43, §§ 2 *et seq.* (1977)	
FLORIDA	Fla. Stat. §§ 381.493 *et seq.* (1972)	1/1/73 (6/30/78)

State	Certificate of Need Legislation	Effective (Termination) Date §1122 Agreement
GEORGIA	Ga. Code §§ 88-3301 *et seq.* (Supp. 1974)	2/27/74
HAWAII	Haw. Rev. Stat. §§ 323D-1 *et seq.* (1974)	8/16/73 (2/28/77)
IDAHO	Idaho Code §§ 39-4901 *et seq.* (Supp. 1980)	2/1/74 (9/30/80)
ILLINOIS	Ill. Rev. Stat. ch. 111 1/2, §§ 1151 *et seq.* (1974)	
INDIANA	Ind. Code §§ 16-1-3.2 *et seq.* (1980)	7/1/73
IOWA	Iowa Code §§ 135.61 *et seq.* (1977)	3/7/73
KANSAS	Kan. Stat. §§ 65-4801 *et seq.* (1972)	
KENTUCKY	Ky. Rev. Stat. §§ 216B.101 *et seq.* (1980) (original version at Ky. Rev. Stat. §§ 216.405 *et seq.* (1972))	3/15/74
LOUISIANA		5/16/73
MAINE	Me. Rev. Stat. tit. 22, §§ 301 *et seq.* (1978)	3/1/73
MARYLAND	Md. Health Code Ann. §§ 556 *et seq.* (1968); Md. Executive and Administrative Department Code Ann. §§ 59C-59L, 206-206D (1968)	2/15/74 (6/30/78)

State	Certificate of Need Legislation	Effective (Termination) Date §1122 Agreement
MASSACHUSETTS	Mass. Gen. Laws ch. 6, § 166; ch. 6A, § 16; ch. 17, § 3; ch. 111, §§ 25B-25H, 51, 52, 71, 73A; ch. 111B, §§ 6, 6A; ch. 155, § 2B (1971)	
MICHIGAN	Mich. Stat. Ann. §§ 14.15(22101) *et seq.* (Supp. 1972)	12/14/73
MINNESOTA	Minn. Stat. §§ 144.50 *et seq.*, §§ 144A.01 *et seq.*, §§ 145.832 *et seq.* (Supp. 1971)	2/25/74
MISSISSIPPI	Miss. Code Ann. §§ 41-7-171 *et seq.* (Supp. 1979)	6/25/73
MISSOURI	Mo. Rev. Stat. §§ 197.300 *et seq.* (1979)	6/16/73 (7/1/76) Reinstated 9/20/79
MONTANA	Mont. Rev. Codes Ann. §§ 50-5-101 *et seq.* (1975)	2/26/74 (2/80)
NEBRASKA	Neb. Rev. Stat. §§ 71-5801 *et seq.* (Supp. 1979)	2/26/73
NEVADA	Nev. Rev. Stat. §§ 439A *et seq.*, §§ 449.001 *et seq.* (1971)	3/15/74 (3/80)

State	Certificate of Need Legislation	Effective (Termination) Date §1122 Agreement
NEW HAMPSHIRE	N.H. Rev. Stat. Ann. §§ 151-C:1 *et seq.* (Supp. 1979)	4/1/73 (6/30/80)
NEW JERSEY	N.J. Rev. Stat. §§ 26:2H-1 *et seq.* (Supp. 1971)	2/28/74
NEW MEXICO	N.M. Stat. Ann. §§ 24-3A-1 *et seq.* (1978)	7/1/73
NEW YORK	N.Y. Pub. Health Law §§ 2800 *et seq.* (1964); N.Y. Mental Hyg. Law §§ 31.01 *et seq.* (1964)	2/28/74 (6/30/80)
NORTH CAROLINA	N.C. Gen. Stat. §§ 131-175 *et seq.* (Supp. 1978)	4/2/73
NORTH DAKOTA	N.D. Cent. Code §§ 23-17.2-01 *et seq.* (1971)	2/28/74
OHIO	Ohio Rev. Code Ann. §§ 3702.51 *et seq.* (1975)	6/28/74 (6/1/78)
OKLAHOMA	Okla. Stat. tit. 63, §§ 2651 *et seq.* (Supp. 1971)	2/27/74
OREGON	Or. Rev. Stat. §§ 441 *et seq.*, §§ 442.015 *et seq.* (1971)	3/1/74 (6/30/80)
PENNSYLVANIA	35 Pa. Cons. Stat. Ann. §§ 448.101 *et seq.* (Supp. 1979)	3/1/73 (8/1/80)

State	Certificate of Need Legislation	Effective (Termination) Date §1122 Agreement
RHODE ISLAND	R.I. Gen. Laws §§ 23-15-1 *et seq.*, §§ 23-16-1 *et seq.*, §§ 23-17-1 *et seq.* (1968)	
SOUTH CAROLINA	S.C. Code §§ 44-7-100 *et seq.* (1971)	3/15/74
SOUTH DAKOTA	S.D. Compiled Laws Ann. §§ 34-7A-22 *et seq.*, §§ 34-12-1, 34-12-2, 34-12-14 (1972)	
TENNESSEE	Tenn. Code Ann. §§ 53-5401 *et seq.* (1973)	
TEXAS	Tex. Rev. Civ. Stat. Ann. art. 4418h, §§ 1.01 *et seq.* (1975)	
UTAH	Utah Code Ann. §§ 26-33-1 *et seq.*, §§ 26-34-1 *et seq.* (Supp. 1979)	2/26/74 (7/1/79)
VERMONT	Vt. Stat. Ann. tit. 18, §§ 2400 *et seq.* (Supp. 1979)	1/2/75 (7/1/79)
VIRGINIA	Va. Code §§ 32.1-93 *et seq.* (1973)	1/2/75 (7/1/79)
WASHINGTON	Wash. Rev. Code §§ 70.40.010 *et seq.* (Supp. 1971)	2/1/74 (7/1/78)

State	Certificate of Need Legislation	Effective (Termination) Date §1122 Agreement
W. VIRGINIA	W. Va. Code §§ 16-2D-1 *et seq.* (1977)	3/15/77
WISCONSIN	Wis. Stat. §§ 150.001 *et seq.* (Supp. 1977)	9/1/73 (7/1/78)
WYOMING	Wyo. Stat. §§ 35-2-101 *et seq.* (1977)	2/28/74 (6/30/79)